Children's Mental Health Fact Sheet for the Classroom

Anxiety Disorders

Symptoms or Behaviors

Students with anxiety disorders may present a variety of behaviors in the classroom. The behaviors expressed in the classroom that are most commonly related to this disorder are:

- Frequent absences
- Refusal to join in social activities
- Isolating behavior
- Many physical complaints
- Excessive worry about homework or grades
- Falling grades
- Frequent bouts of tears
- Frustration
- Fear of new situations
- Drug or alcohol abuse

About the Disorder

All children feel anxious at times. Many young children, for example, show great distress when separated from their parents. Preschoolers are often frightened of strangers, thunderstorms, or the dark. These are normal and usually short-lived anxieties. But some children suffer from anxieties severe enough to interfere with the daily activities of childhood or adolescence.

- **Generalized Anxiety Disorder.** Students experience extreme, unrealistic worry unrelated to recent events. They are often self-conscious and tense with a very strong need for reassurance. They may suffer from aches and pains that appear to have no physical basis.

- **Phobias.** Students suffer unrealistic and excessive fears. Specific phobias may center on animals, storms, waters, or situations such as being in an enclosed space.

- **Social phobias** may center on a fear of being watched, criticized, or judged harshly by others. Because young people with phobias avoid the objects and situations they fear, this disorder can greatly restrict their lives. This fear can be so debilitating it may keep students from going to school.

- **Panic Disorder.** Students suffer repeated panic attacks without apparent cause. These attacks are periods of intense fear accompanied by pounding heartbeat, sweating, dizziness, nausea, or a feeling of imminent death. Students with panic disorder will go to great lengths to avoid a panic attack. This may mean refusal to attend school or be separated from parents.

- **Obsessive-Compulsive Disorder.** Students become trapped in a pattern of repetitive thoughts and behaviors. These may include repeated hand washing, counting, or arranging and rearranging objects.

- **Post-Traumatic Stress Disorder.** Students experience strong memories, flashbacks, or troublesome thoughts of traumatic events. These may include physical or sexual abuse or being a victim or witness of violence or disaster, such as a shooting, bombing or hurricane. Young people with this disorder may try to avoid anything associated with the trauma. They also tend to over-react when startled or have difficulty sleeping.

Anxiety Disorders

Educational Implications

Because students with anxiety disorder are easily frustrated, they may have difficulty completing their work. They may worry so much about getting everything right that they take much longer to finish than other students. Or they may simply refuse to begin out of fear that they won't be able to do anything right. Their fears of being embarrassed, humiliated or failing may result in school avoidance. Getting behind in their work due to numerous absences often creates a cycle of fear of failure, increased anxiety, and avoidance, which leads to more absences.

Instructional Strategies and Classroom Accommodations

- Allow students to contract a flexible deadline for worrisome assignments.
- Have the student check with the teacher or the teacher check with the student to make sure that assignments have been written down correctly. Many teachers will choose to initial an assignment notebook to indicate that information is correct.
- Consider modifying or adapting the curriculum to better suit the student's learning style, which will lessen his/her anxiety.
- Post the daily schedule where it can easily be seen so students know what to expect.
- Encourage follow-through on assignments or tasks, yet be flexible on deadlines.
- Reduce work load at home or school when necessary.
- Keep as much of the child's regular schedule as possible.
- Encourage school attendance - to prevent absences, modify the child's class schedule or reduce the time spent at school.

For additional suggestions on classroom strategies and modifications see "A Teacher's Guide to Children's Mental Health" available from MACMH.

RESOURCES

Anxiety Disorders Association of America
8730 Georgia Ave, Suite 600
Silver Spring, MD 20910
240-485-1001
Fax: 240-485-1035
www.adaa.org

Anxiety Disorders Education Program
National Institute of Mental Health
6001 Executive Boulevard
Rm 8184, MSC 9663
Bethesda, MD 20852-9663
866-615-6464 or 301-443-4513
Fax: 301-443-4279
www.nimh.nih.gov/healthinformation/anxietymenu.cfm
Free educational materials for professionals and the public

National Anxiety Foundation
3135 Custer Drive
Lexington, KY 40517
800-269-7954
http://lexington-on-line.com/naf.html
Information on anxiety disorders, reading lists, referrals to other sources of information

Obsessive Compulsive Foundation
676 State Street
New Haven, CT 06511
203-401-2070
Fax: 203-401-2076
www.ocfoundation.org

Asperger's Syndrome

Symptoms or Behaviors

- Adult-like pattern of intellectual functioning and interests, combined with social and communication deficits
- Isolated from their peers
- Other students consider them odd
- Rote memory is usually quite good; they may excel at math and science
- Clumsy or awkward gait
- Difficulty with physical activities and sports
- Repetitive pattern of behavior
- Preoccupations with one or two subjects or activities
- Under or over sensitivity to stimuli such as noise, light or unexpected touch
- Victims of teasing and bullying

About the Disorder

Asperger's Syndrome, a subset of the autism spectrum disorders, was first identified in the 1940s. Before knowledge of the diagnosis was expanded, the term "high functioning autism" was usually used. An increasing number of children are now being identified with this disorder.

Asperger's is a neurobiological disorder that can impact sensory systems, visual and auditory processing, and behavior. Students with Asperger's Syndrome are usually highly verbal and test with average to above-average IQs.

A diagnosis of Asperger's Syndrome requires an atypical pattern of behaviors, interests, and activities. This neurological disorder impacts cognition, language, socialization, sensory issues, visual processing, and behavior. There is often a preoccupation with a single subject or activity. Students may also show excessive rigidity (resistance to change), nonfunctional routines or rituals, repetitive motor movements, or persistent preoccupation with a part of an object rather than functional use of the whole object (i.e., spinning the wheels of a toy car rather than "driving" it around). The most outstanding characteristic of a child with Asperger's is impairment of social interactions, which may include failure to use or comprehend nonverbal gestures, failure to develop age-appropriate peer relationships, and a lack of empathy.

Many parents and professionals have identified successful adults who may have undiagnosed Asperger's Syndrome because they have learned to compensate for their differences and use their fixations to their advantage when working toward achieving difficult goals. For other students, ongoing needs may lead to a request for help from social services. Students may qualify as having a "related condition," especially if a functional skills test like the Vineland shows severe delays in social, self-care, and personal safety areas.

Asperger's Syndrome

Educational Implications

Many children with Asperger's have difficulty understanding social interactions, including nonverbal gestures. They may fail to develop age-appropriate peer relationships, or be unable to share interests or show empathy. When confronted by changes in school routine, they may show visible anxiety, withdraw into silence, or burst into a fit of rage. Although students with Asperger's may often appear to have a large vocabulary, sometimes sounding like "little professors," they can be very literal and have great difficulty using language in a social context. They may like school, but wish the other children weren't there.

Instructional Strategies and Classroom Accommodations

- Create a structured, predictable, and calming environment.
- Foster a climate of tolerance and understanding in the classroom. Consider assigning a peer helper to assist the student in joining group activities and socializing.
- Enjoy and make use of your student's verbal and intellectual skills. Fixations can be used by making their chosen subject the center of teaching and using the student's expertise to raise peer interest and respect (i.e., have him give a report or make a model of his favorite subject to share with the class.)
- Use direct teaching to increase socially acceptable behaviors, expected greetings and responses, and group interaction skills. Demonstrate the impact of words and actions on other people during real-life interactions and increase awareness of emotions, body language, etc.
- Create a standard way of presenting change in advance of the event. A key phrase like "Today will be different" may be helpful if used consistently. You may want to explain the changes — for example, a substitute teacher — privately as well as with the class.
- Learn the usual triggers and the warning signs of a rage attack or "melt-down" and intervene early, before control is lost. Help your student learn self-calming and self-management skills. Remain calm and non-judgmental to reduce stress, remind yourself that your student "can't" rather than "won't" react as others do.
- Provide whatever support and information you can to the parents. Children with Asperger's Syndrome often have sleep disorders and the family may be sleep-deprived. Other parents show frustration due to the long search for a diagnosis and services. They may also face disbelieving professionals or family members who erroneously blame poor parenting for the behaviors they see.

For additional suggestions on classroom strategies and modifications see "A Teacher's Guide to Children's Mental Health" available from MACMH.

RESOURCES

Autism Society of America
7910 Woodmont Avenue, Suite 300
Bethesda, MD, 20814-3067
1-800-3AUTISM
www.autism-society.org

Autism Society of Minnesota
2380 Wycliff
St. Paul, MN 55114
651-647-1083
www.ausm.org
Provides introductory classes, parent support, information and referral, and a specialized summer camp program

Center for the Study of Autism
P.O. Box 4538
Salem, OR 97302
www.autism.org
Provides an overview of autism and related disorders and valuable links

Video:
Visual Supports in the Classroom for Students with Autism and Related Pervasive Developmental Disorders.

Attention Deficit Hyperactivity Disorder

Symptoms or Behaviors

The U.S Department of Health and Human Services lists three forms of ADHD, each with different symptoms.

Children with Inattentive Disorder may:

- •Have short attention spans
- •Have problems with organization
- •Fail to pay attention to details
- •Be unable to maintain attention
- •Have trouble listening even when spoken to directly
- •Fail to finish their work
- •Make lots of mistakes

Children with Hyperactive-Impulsive Disorder tend to:

- •Fidget and squirm
- •Have difficulty staying seated
- •Talk too much
- •Have trouble taking turns in games or activities
- •Interrupt or intrude on others

Children with combined Attention Deficit Hyperactivity Disorder show symptoms of both inattention and hyperactivity or impulsivity.

About the Disorder

Children and teens with Attention Deficit Hyperactivity Disorder (ADHD) may be overactive and/or unable to pay attention and stay on task. They tend to be impulsive and accident-prone. They may answer questions before raising their hand, forget things, fidget, squirm, or talk too loud. On the other hand, some students with this disorder may be quiet and "spacey" — inattentive, forgetful, and easily distracted.

Symptoms may be situation specific. For example, students with ADHD may not exhibit some behaviors at home if that environment is less stressful, less stimulating, or is more structured than the school setting. Or students may be able to stay on task when doing a project they find enjoyable — such as an art project — and they may not when they have to work on something that is more difficult for them.

An estimated 5 percent of children have a form of ADHD. More boys than girls are diagnosed with ADHD, and it is the leading cause of referrals to mental health professionals and special education programs, as well as the juvenile justice system. Students with ADHD who are not hyperactive tend to be overlooked in school or dismissed as "quiet and unmotivated" because they can't get organized or do their work on time.

Students with ADHD are at higher risk for mood disorders such as depression, learning disorders, anxiety disorders, and conduct disorder. Without proper treatment, children are at risk for school failure. They may also have difficulty maintaining friendships and their self-esteem may suffer from experiencing frequent failure because of their disability.

A student whom you suspect to have ADHD should be referred for a mental health assessment. Many children benefit from medications. This must be managed by an experienced professional, such as a child psychiatrist, pediatrician or neurologist who is experienced in treating ADHD. In addition, mental health professionals can work with the family and school personnel to find ways to teach children with ADHD more effectively.

Remember that ADHD is a neurobiological disorder. Students can't get organized or learn social skills on their own, but you can find interventions that greatly increase their capacity to succeed.

Attention Deficit Hyperactivity Disorder

Educational Implications

Children with ADD/ADHD may have trouble staying on task or finishing assignments. They may lose books, supplies, and homework. Students may blurt out answers before teachers can finish asking the question. They may be irritable, impatient, hard to discipline, clumsy, reckless, and accident-prone. Other children may dislike them. They may come to see themselves as bad and lazy, and powerless to do any better. This "chain of failure" can lead to depression, low self-esteem, behavior problems, and, of course, school failure.

Instructional Strategies and Classroom Accommodations

- Have the student check with the teacher or the teacher check with the student to make sure that assignments have been written down correctly.
- Consider a Functional Behavioral Assessment (FBA). Understanding the purpose or function of the student's behaviors will help you respond with effective interventions.
- Provide consistent structure and clearly define your expectations.
- When giving instructions or tasks it's helpful to break them into numerous steps. Give the student one or two steps at a time.
- Allow student to turn in late work for full credit.
- Allow student to redo assignments to improve score or final grade.
- Allow student to move about within reason.
- Catch your student being good. Look for positive behaviors to reward.
- Have a secret signal to help the child recognize that he/she has gotten off task and must re-focus. This helps the student stay on task without embarrassment.
- Use large graph paper in math class to provide a structured method for writing numbers.
- Allow a child to use tables or formulas – memorization may be very difficult.
- Allow the child to answer directly in a booklet. This reduces the amount of movement and distraction during an assignment.
- Teach students with ADHD self-monitoring techniques. Help them identify social cues from their peers and adults that would suggest a need for a behavior change. Also help students identify an "aid or technique" that will help them calm down or refocus, such as exercise, short breaks away from stimulation, or meditation.
- Stress and pressure can break down a student's self-control and lead to inappropriate behaviors. Reduce the stress and pressure whenever possible.

For additional suggestions on classroom strategies and modifications see "A Teacher's Guide to Children's Mental Health" available from MACMH.

RESOURCES

Attention Deficit Information Network
58 Prince St
Needham, MA 02492
781-455-9895
http://www.addinfonetwork.com
Nonprofit organization that offers support and information to families of children and adults with ADD

National Attention Deficit Disorder Association
P.O. Box 543
Pottstown, PA 19464
Phone: 484-945-2101
Fax: 610-970-7520
www.add.org
In addition to information, this site provides many links to other web pages of interest

Publication:
Greene, Ross W. *The Explosive Child: A New Approach for Understanding Easily Frustrated, "Chronically Inflexible" Children.* Harper Collins, 1998.

Bipolar Disorder (Manic-Depressive Illness)

Symptoms or Behaviors

- An expansive or irritable mood
- Depression
- Rapidly changing moods lasting a few hours to a few days
- Explosive, lengthy, and often destructive rages
- Separation anxiety
- Defiance of authority
- Hyperactivity, agitation, and distractibility
- Strong and frequent cravings, often for carbohydrates and sweets
- Excessive involvement in multiple projects and activities
- Impaired judgment, impulsivity, racing thoughts, and pressure to keep talking
- Dare-devil behaviors
- Inappropriate or precocious sexual behavior
- Delusions and hallucinations
- Grandiose belief in own abilities that defy the laws of logic (become a rockstar overnight, for example)

About the Disorder

Bipolar disorder, also known as Manic-Depressive Illness, is a brain disorder that causes unusual shifts in a person's mood, energy, and ability to function. Different from the normal ups and downs that everyone goes through, the symptoms of bipolar disorder are severe. They can result in damaged relationships, poor job or school performance, and even suicide.

More than 2 million American adults, or about one percent of the population age 18 and older in any given year, have bipolar disorder. Children and adolescents can also develop bipolar disorder. It is more likely to affect the children of parents who have the illness. Like diabetes or heart disease, bipolar disorder is a long-term illness that must be carefully managed throughout a person's life.

Unlike many adults with bipolar disorder, whose episodes tend to be more clearly defined, children and young adolescents with the illness often experience very fast mood swings between depression and mania many times within a day. Children with mania are more likely to be irritable and prone to destructive tantrums than to be overly happy and elated. Mixed symptoms also are common in youths with bipolar disorder. Older adolescents who develop the illness may have more classic, adult-type episodes and symptoms.

Bipolar disorder in children and adolescents can be hard to tell apart from other problems that may occur in these age groups. For example, while irritability and aggressiveness can indicate bipolar disorder, they also can be symptoms of attention deficit hyperactivity disorder, conduct disorder, oppositional defiant disorder, or other types of mental disorders more common among adults such as schizophrenia. Students with bipolar disorder may be prone to drug use which can aggravate symptoms.

For any illness, however, effective treatment depends on appropriate diagnosis. Children or adolescents with emotional and behavioral symptoms should be carefully evaluated by a mental health professional. In addition, adolescents with bipolar disorder are at a higher risk for suicide. Any child or adolescent who has suicidal feelings, talks about suicide, or attempts suicide should be taken seriously and should receive immediate help from a mental health professional.

Bipolar Disorder (Manic-Depressive Illness)

Educational Implications

Students may experience fluctuations in mood, energy and motivation. These fluctuations may occur hourly, daily, in specific cycles, or seasonally. As a result, students may have difficulty concentrating and remembering assignments, understanding assignments with complex directions, or reading and comprehending long, written passages of text. Students may experience episodes of overwhelming emotion such as sadness, embarrassment, or rage. They may also have poor social skills and have difficulty getting along with their peers.

Instructional Strategies and Classroom Accommodations

- Provide the student with recorded books as an alternative to self-reading when the student's concentration is low.
- Break assigned reading into manageable segments and monitor the student's progress, checking comprehension periodically.
- Devise a flexible curriculum that accommodates the sometimes rapid changes in the student's ability to perform consistently in school.
- When energy is low, reduce academic demands; when energy is high, increase opportunities for achievement.
- Identify a place where the student can go for privacy until he or she regains self-control.

— These are suggestions from the Child and Adolescent Bipolar Foundation.

For additional suggestions on classroom strategies and modifications see "A Teacher's Guide to Children's Mental Health" available from MACMH.

RESOURCES

Child & Adolescent Bipolar Foundation
1187 Willmette Avenue, PMB #331
Willmette, IL 60091
847-256-8525
www.bpkids.org
Educates families, professionals, and the public about early-onset bipolar disorders

Depression & Bipolar Support Alliance (BPSA)
730 North Franklin Street, Suite 501
Chicago, IL 60610
800-826-3632 or 312-642-0049
www.dpsalliance.org
Support groups, patient support, patient assistance programs, advocacy, publications, referrals, book catalog

National Alliance for the Mentally Ill Children and Adolescents Network
Colonial Place Three
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
800-950-6264
www.nami.org
Medical and legal information, helpline, research, publications, books

Depression Education Program, National Institute of Mental Health
6001 Executive Boulevard
Rm 8184, MSC 9663
Bethesda, MD 20852-9663
866-615-6464 or 301-443-4513
www.nimh.nih.gov/healthinformation/depressionmenu.cfm
Free educational materials for professionals and the public

Conduct Disorder

About the Disorder

Children and adolescents with conduct disorder are highly visible, demonstrating a complicated group of behavioral and emotional problems. Serious, repetitive, and persistent misbehavior is the essential feature of this disorder.

These behaviors fall in four main groups: aggressive behavior toward people or animals, destruction of property, deceitfulness or theft, and serious violations of rules.

To receive a diagnosis of conduct disorder, a child or adolescent must have displayed three or more characteristic behaviors in the past 12 months. At least one of these behaviors must have been evident during the past six months.

Diagnosing conduct disorder can be a dilemma because children are constantly changing. This makes it difficult to discern whether the problem is persistent enough to warrant a diagnosis. In some cases, what appears to be conduct disorder may be a problem adjusting to acute or chronic stress. Many children with conduct disorder also have learning disabilities and about one-third are depressed. Many children stop exhibiting behavior problems when they are treated for depression.

The U.S. Department of Health and Human Services estimates that between six and sixteen percent of males and two to nine percent of females under age 18 have conduct disorder ranging in severity from mild to severe.

The social context in which a student lives (poverty, high crime areas, for example) may influence what we view as antisocial behavior. In these cases, a diagnosis of conduct disorder can be misapplied to individuals whose behaviors may be protective or "normal" within the cultural context.

Symptoms or Behaviors

- Bullying or threatening classmates and other students
- Poor attendance record or chronic truancy
- History of frequent suspension
- Little empathy for others and a lack of appropriate feelings of guilt and remorse
- Low self-esteem masked by bravado
- Lying to peers or teachers
- Stealing from peers or the school
- Frequent physical fights – use of a weapon
- Destruction of property

A child with suspected Conduct Disorder needs to be referred for a mental health assessment. If the symptoms are mild, the student may be able to receive services and remain in the regular school environment.

Conduct Disorder

Educational Implications

Students with conduct disorder like to engage in power struggles. They often react badly to direct demands or statements such as: "You need to..." or "You must..." They may consistently challenge class rules, refuse to do assignments and argue or fight with other students. This behavior can cause significant impairment in both social and academic functioning. They also work best in environments with high staff/student ratios, one-on-one situations, or self-contained programs, when there is plenty of structure and clearly defined guidelines. Their frequent absences and refusal to do assignments often lead to academic failure.

Instructional Strategies and Classroom Accommodations

- Make sure curriculum is at appropriate level. When work is too hard, students become frustrated. When it is too easy, they become bored. Remember that praise is important but needs to be sincere.
- Consider the use of technology. Students with Conduct Disorder tend to work well on computers with active programs.
- Students with conduct disorder often do well in programs that allow them to work outside of the school setting.
- Try to monitor your impressions, keep them as neutral as possible, communicate a positive regard for the students, and give them the benefit of the doubt whenever possible.
- Maintain calm, respect and detachment. Avoid power struggles.
- Give the student options. Stay away from direct demands or statements such as: "You need to..." or "You must..."
- Avoid escalating prompts such as shouting, touching, nagging, or cornering the student.
- Establish clear classroom rules. Be clear about what is nonnegotiable.
- Systematically teach social skills including anger management, conflict resolution strategies, and how to be assertive in an appropriate manner.
- Maximize the performance of low-performing students through the use of individualized instruction, the breaking down of academic tasks, debriefing, coaching, and providing positive incentives.
- Structure activities so the student with conduct disorder is not always left out or the last one picked.

For additional suggestions on classroom strategies and modifications see "A Teacher's Guide to Children's Mental Health" available from MACMH.

RESOURCES

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Avenue, NW
Washington, DC 20016-3007
800-333-7636
www.aacap.org
Information on child and adolescent psychiatry, fact sheets, current research, practice guidelines, managed care information

Publications:

Greene, Ross W. *The Explosive Child: A New Approach for Understanding Easily Frustrated, "Chronically Inflexible" Children.* Harper Collins, 1998.

Otnow-Lewis, Dorothy. *Conduct Disorder and Juvenile Delinquency.* In Harold I. Kaplan and Benjamin J. Sadock, eds. *Comprehensive Textbook of Psychiatry, 4th Edition.* Baltimore, Williams and Wilkins, 1985.

Kaplan, William H. *Conduct Disorder.* In Clarice J. Kestenbaum and David T. Williams, eds. *Handbook of Clinical Assessment of Children and Adolescents.* New York, N.Y.U. Press, 1988.

Depression

Symptoms or Behaviors

- Sleeping in class
- Defiant or disruptive
- Refusal to participate in school activities
- Excessive tardiness
- Not turning in homework assignments, failing tests
- Fidgety or restless, distracting other students
- Isolating, quiet
- Frequent absences
- Failing grades
- Refusal to do school work, and general non-compliance with rules
- Talks about dying or suicide

About the Disorder

All children feel sad or blue at times, but feelings of sadness that persist for weeks or months may be a symptom of major depressive disorder or dysthymic disorder (chronic depression). These depressive disorders are more than “the blues”; they affect a young person’s thoughts, feelings, behavior, and body, and can lead to school failure, alcohol or drug abuse, and even suicide. Depression is one of the most serious mental, emotional, and behavior disorders suffered by children and teens.

Recent studies reported by the U.S. Department of Health and Human Services show that as many as one in every 33 children may have depression; among adolescents, the ratio may be as high as one in eight. Boys appear to suffer more depression in childhood. During adolescence, the illness is more prevalent among girls.

Depression that occurs in childhood is harder to diagnose, more difficult to treat, more severe, and more likely to reoccur than depression that strikes later in life. Depression also affects a child’s development. A depressed child may get “stuck” and be unable to pass through normal developmental stages.

The most common symptoms of depression in children and teens are:

- Sadness that won’t go away
- Thoughts or expressions of death or suicide
- Changes in eating and sleeping patterns
- Persistent boredom, low energy, or poor concentration
- Hopelessness
- Self-deprecating remarks

Students who used to enjoy playing with friends may now spend most of their time alone, or they may start “hanging out” with a completely different peer group. Activities that were once fun hold no interest. Depressed teens may “self-medicate” with alcohol or drugs.

Children who cause trouble at home or at school may actually be depressed although they may not seem sad. Younger children may pretend to be sick, be overactive, cling to their parents, seem “accident prone”, or refuse to go to school. Older children and teens often refuse to participate in family and social activities and stop paying attention to their appearance. They may also be restless, grouchy or aggressive.

Perhaps the most frightening possible outcome of depression is suicide, which occurs even among young children. Suicide is the 3rd leading cause of death for 15-24 year olds nationally, and the 6th leading cause of death for 5-15 year olds. In 8 out of every 10 suicides, a verbal or behavioral warning was given. Any child or adolescent who talks about suicide or dying, makes hints alluding to not being around, or attempts suicide, should be taken very seriously and should receive immediate help from a mental health professional.

Most mental health professionals believe that depression has a biological origin. Research indicates that children have a greater chance of developing depression if one or both of their parents have suffered from this illness.

Depression

Educational Implications

Students experiencing depression may display a marked change in their interest in schoolwork and activities. Their grades may drop significantly due to lack of interest, loss of motivation, or excessive absences. They may withdraw and refuse to socialize with peers or participate in group projects.

Instructional Strategies and Classroom Accommodations

- Reduce some classroom pressures.
- Break tasks into smaller parts.
- Reassure students that they can catch up. Show them the steps they need to take — be flexible and realistic about your expectations. (School failures and unmet expectations can exacerbate the depression.)
- Help students use realistic and positive statements about their performance and outlook for the future.
- Help students recognize and acknowledge positive contributions and performance.
- Depressed students may see issues in black and white terms — all bad or all good. It may help to keep a record of their accomplishments and show them to the student occasionally.
- Encourage gradual social interaction (i.e. small group work).
- Ask parents what would be helpful in the classroom to reduce pressure or motivate the child.

For additional suggestions on classroom strategies and modifications see "A Teacher's Guide to Children's Mental Health" available from MACMH.

RESOURCES

Center for Mental Health Services: Child, Adolescent, and Family Branch
5600 Fishers Lane, Room 11C-16
Rockville, MD 20857
301-443-1333
KEN Clearinghouse: 800-789-2647
www.mentalhealth.org

Educational Resources Information Center (ERIC)
2277 Research Boulevard, 6M
Rockville, MD 20850
800-538-3742 or 301-519-5157
Fax: 301-519-6760
www.eric.ed.gov
Information on disabilities and gifted education, question/answer service, educational materials with extensive database, research information, referrals to other organizations

National Foundation for Depressive Illnesses, Inc
P.O. Box 2257
New York, NY 10116
800-239-1265
www.depression.org
Provides information for the public and professionals in regards to the symptoms and research of depression

SA/VE (Suicide Awareness Voices of Education)
7317 Cahill Road, Ste 207
Edina, MN 55439
952-946-7998
www.save.org

Eating Disorders

Symptoms or Behaviors

- Perfectionistic attitude
- Impaired concentration
- Withdrawn
- All or nothing thinking
- Depressed mood or mood swings
- Self-deprecating statements
- Irritability
- Lethargy
- Anxiety
- Fainting spells and dizziness
- Headaches
- Hiding food
- Avoiding snacks or activities that include food
- Frequent trips to the bathroom

About the Disorder

Nearly all of us worry about our weight at some time in our lives. But some individuals become so obsessed with their weight and the need to be thin that they develop an eating disorder. The two most common eating disorders are anorexia nervosa and bulimia nervosa.

Once seen mostly in teens and young adults, these disorders are increasingly seen in younger children as well. In movies, magazines, and on television, thin is in. Children as young as four and five years of age are expressing the need to diet, and it's estimated that 40 percent of nine-year-olds have already dieted. Eating disorders are not limited to girls and young women — between 10 and 20 percent of adolescents with eating disorders are boys.

Individuals with *anorexia* fail to maintain a minimally normal body weight. They engage in abnormal eating behavior and excessive concerns about food. They are intensely afraid of even the slightest weight gain, and their perception of their body shape and size is significantly distorted. Many individuals with anorexia are compulsive and excessive about exercise. Children and teens with this disorder tend to be perfectionist and over achieving. In teenage girls with anorexia, menstruation may cease, leading to the same kind of bone loss suffered by menopausal women.

Children and teens with *bulimia* go on eating binges during which they compulsively consume abnormally large amounts of food within a short period of time. To avoid weight gain, they engage in inappropriate compensatory behavior including the use of laxatives, diuretics, enemas, self-induced vomiting, fasting, and excessive exercise.

Athletes such as wrestlers, dancers, or gymnasts may fall into disordered eating patterns in an attempt to stay thin or "make their weight." This can lead to a full-blown eating disorder.

Adolescents who have eating disorders are obsessed with food. Their lives revolve around thoughts and worries about their weight and their eating. Youth who suffer from eating disorders are at risk for alcohol and drug use as well as depression.

If you suspect a student may be suffering from an eating disorder, refer that student immediately for a mental health assessment. Without medical intervention, an individual with an eating disorder faces serious health problems and — in extreme cases — death.

Eating Disorders

Educational Implications

Students with eating disorders may look like model students, often leading the class and being very self demanding. Others may show poor academic performance. When students with eating disorders are preoccupied with body image and controlling their food intake, they may have short attention spans and poor concentration. These symptoms may also be due to a lack of nutrients from fasting and vomiting. Thedr students often lack the energy and drive necessary to complete assignments or homework.

Instructional Strategies and Classroom Accommodations

- Stress acceptance in your classroom; successful people come in all sizes and shapes.
- Watch what you say. Comments like "You look terrible," "What have you eaten today?" or "I wish I had that problem" are hurtful and discouraging.
- Stress progress, not perfection.
- Avoid pushing students to excel beyond their capabilities
- Avoid high levels of competition.
- Reduce stress where possible, by reducing assignments or extending deadlines.

For additional suggestions on classroom strategies and modifications see "A Teacher's Guide to Children's Mental Health" available from MACMH.

RESOURCES

Anorexia Nervosa and Related Eating Disorders
P.O. Box 5102
Eugene, OR 97405
www.anred.com

Academy for Eating Disorders National Office
60 Revere Drive, Suite 500
Northbrook, IL 60062
847-498-4274
FAX: 847-480-9282
www.aedweb.org
Information, advocacy, newsletter

National Association of Anorexia Nervosa and Associate Disorders
P.O. Box 7
Highland Park, IL 60035
847-831-3438
www.anad.org
Promotes and develops research projects; customized information packets upon request

National Eating Disorders Association
603 Stewart Street, Suite 803
Seattle, WA 98101
800-931-2237
www.nationaleatingdisorders.org
Educational resources on prevention for schools, health professional and individuals

Children's Mental Health Fact Sheet for the Classroom

Fetal Alcohol Syndrome/Fetal Alcohol Effects (FAS/FAE)

Symptoms or Behaviors

Early Childhood (1-5 yrs):
- Speech or gross motor delays
- Tactile sensitivity or insensitivity
- Erratic sleeping/eating habits
- Lack of stranger anxiety
- Rage
- Poor/limited abstracting ability

Elementary years:
- Immature
- Blames others for all problems
- Volatile and impulsive
- Socially isolated and emotionally disconnected
- High need for stimulation
- Possible Fascination with knives/fire

Adolescent years (13-18 yrs):
- No personal boundaries
- Naïve, suggestible, a follower
- Poor judgment and memory
- Isolated, sometimes depressed and/or suicidal
- Poor social skills
- Unable to link action and consequence/doesn't understand responsibility
- Doesn't learn from mistakes

About the Disorder

Fetal Alcohol Syndrome (FAS) is brain damage and physical birth defects caused by a woman drinking alcohol during pregnancy. FAS can include growth deficiencies, central nervous system dysfunction that may include low IQ or mental retardation, and abnormal facial features (for example, small eye openings, small upturned nose, thin upper lip, small lower jaw, low set ears, and an overall small head circumference).

Children lacking the distinguishing facial features may be labeled with fetal alcohol effects (FAE). A diagnosis of FAE may make it more difficult to meet the criteria for many services or accommodations. The Institute of Medicine has recently coined a new term to describe the condition in which only central nervous system abnormalities are present from prenatal alcohol exposure: alcohol related neurodevelopmental disabilities (ARND).

Learning is not automatic for them. Due to organic brain damage, memory retrieval is impaired, making any learning difficult — academic and social. Many of these children have problems with communication, especially social communication, even though they may have strong verbal skills. They often have trouble interpreting actions and behaviors of others, or reading "social cues." Abstract concepts are especially troublesome. They often appear irresponsible, undisciplined, and immature, as they lack critical thinking skills including judgment, reasoning, problem solving, predicting, and generalizing. In general, any learning is from a concrete perspective, but even then only through ongoing repetition.

Because children with FAS/FAE don't internalize morals, ethics or values (these are abstract concepts), they don't understand how to do or say the appropriate thing. They also do not learn from past experience; punishment doesn't seem to faze them and they often repeat the same mistakes. They "live in the moment." Immediate wants or needs take precedence, and they don't understand the concept of cause and effect, or that there are consequences to their actions. These factors may result in serious behavior problems, unless their environment is closely monitored, structured and consistent.

FAS is an irreversible, lifelong condition that affects every aspect of a child's life and the lives of his or her family members. With identification and diagnosis, however, a child with FAS/FAE can receive services that will help maximize his or her potential.

Much of this information was taken directly from handouts provided by ARC Northland-Duluth. Used with permission.

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165 Western Ave, Suite 2, St. Paul, MN 55102 • www.macmh.org

Fetal Alcohol Syndrome/Fetal Alcohol Effects (FAS/FAE)

Educational Implications

Children with FAS need more intense supervision and structure than other children. They are impulsive, uninhibited, and over-reactive. Social skills such as sharing, taking turns, and cooperating in general are usually not understood, and these children tend to play alongside others, but not with them. In addition, sensory integration problems are common, which create tendencies to be high strung, sound-sensitive, and easily over-stimulated. Other students often find them irritating to be around.

Although they can focus their attention on the task at hand, they have multiple obstacles to learning. Since they don't understand ideas, concepts, or abstract thought, they may have verbal ability without actual understanding. Even simple tasks require intense mental effort because of their cognitive impairment. This can result in mental exhaustion, which adds to behavior problems. In addition, since their threshold for frustration is low, they may fly into rages and temper tantrums.

A common impairment is with short-term memory, and in an effort to please, students often will make up an answer when they don't remember one. This practice can apply to anything, including schoolwork or behaviors. Since they live in the moment and don't connect their actions with consequences, they don't learn from their experience that making up answers is not appropriate.

Instructional Strategies and Classroom Accommodations

- Be as consistent as possible. Re-learning and change are very difficult.
- Use a lot of repetition.
- Use multi-sensory instruction (visual, olfactory, kinesthetic, tactile, and auditory).
- Be specific, yet brief. Tell them step-by-step, one step at a time. Use short sentences, simple words, and always be concrete.
- Don't ask "why" questions as they are abstract.
- Increase supervision with the emphasis on positive reinforcement.
- Model appropriate behavior.
- Avoid long periods of deskwork (these children must move).
- Post all rules and schedules. Repeatedly go over the rules and their meanings aloud, at least once a day.
- Use immediate discipline.
- When talking directly to the student, be sure to say his or her name.
- Be positive. Positively recognize partially correct responses.

For additional suggestions on classroom strategies and modifications see "A Teacher's Guide to Children's Mental Health" available from MACMH.

RESOURCES

ARC Northland FAS/E Diagnostic Clinic and Resources
201 Ordean Building
424 West Superior St., RM 201
Duluth, MN 55802
218-726-4725
or 1-800-317-6475
fasclinic.an@charterinternet.net
Call for information about a diagnostic clinic in your area

Fetal Alcohol Syndrome Family Resource Institute
P.O. Box 2525
Lynnwood, WA 98036
253_531-2878
www
.fetalalcoholsyndrome.org

National Organization on Fetal Alcohol Syndrome
www.nofas.org

Thunder Spirit Center
Chrysalis
4432 Chicago Avenue South,
Minneapolis, MN 55407
612-871-0118
www.chrysaliswomen.org
Provides services to families affected by FAS/E

Publications:
Fetal Alcohol Syndrome: A Guide for Families & Communities. Brookes Publishing Company
PO Box 10624
Baltimore. MD 21285-0624.

Obsessive-Compulsive Disorder

Symptoms or Behaviors

- Unproductive time retracing the same word or touching the same objects over and over
- Erasing sentences or problems repeatedly
- Counting and recounting objects, or arranging and rearranging objects at their desk
- Frequent trips to the bathroom
- Poor concentration
- Falling grades
- School avoidance
- Anxiety or depressed mood

About the Disorder

Obsessive-Compulsive Disorder (OCD) has a neurobiological basis. This means it is a biological disease of the brain, just as diabetes is a biological disease of the pancreas. OCD is not caused by bad parenting, poverty, or other environmental factors.

Children with OCD may have obsessive thoughts and impulses that are recurrent, persistent, intrusive, and senseless — they may, for instance, excessively worry about contamination from germs. They may also perform repetitive behaviors in a ritualistic manner — for example, they may engage in compulsive hand washing. An individual with OCD will often perform their rituals such as hand washing, counting, or cleaning in an attempt to neutralize the anxiety caused by their obsessive thoughts.

OCD is sometimes accompanied by other disorders such as substance abuse, attention deficit hyperactivity disorder, eating disorders, or other anxiety disorders. When a student has another disorder, the OCD is more difficult to treat or diagnose. Symptoms of OCD may coexist or be part of a spectrum of other brain disorders, such as Tourette's disorder or autism.

New research done at the National Institute of Mental Health suggests that OCD in some individuals may be an auto-immune response triggered by antibodies produced to counter strep infection in childhood. This phenomenon is know as PANDAS.

Students with OCD often experience high levels of anxiety and shame about their thoughts and behavior. Their thoughts and behaviors are so time consuming that they interfere with everyday life.

Common obsessions are:

- Aggression
- Loss
- Doubt
- Sex
- Religion
- Contamination
- Orderliness and symmetry

Common compulsive behaviors are:

- Hoarding
- Avoiding
- Counting
- Cleaning and washing
- Reassurance seeking
- Repeating
- Touching
- Checking
- Ordering or arranging

Children who show symptoms of OCD should be referred for a mental health assessment. Behavior therapy and pharmacological treatment have both proven successful in the treatment of this disorder.

Obsessive-Compulsive Disorder

Educational Implications

Compulsive activities often take up so much time that students can't concentrate on their schoolwork, leading to poor or incomplete work and even school failure. Students with OCD may feel isolated from their peers, in part because their compulsive behavior leaves them little time to interact or socialize with their classmates. They may avoid school because they are worried that teachers or their peers will notice their odd behaviors.

Instructional Strategies and Classroom Accommodations

- Try to accommodate situations and behaviors that the student has no control over.
- Educate the student's peers about OCD.
- Be attentive to changes in the student's behavior.
- Try to redirect the student's behavior. This works better than using "consequences."
- Allow the student to do assignments such as "oral reports" in place of writing.
- Allow the student to turn in late work for full credit.
- Allow the student to redo assignments to improve scores or final grades.
- Consider a Functional Behavioral Assessment (FBA). Understanding the purpose or function of the student's behaviors will help you respond with effective interventions and strategies. For example, a punitive approach or punishment may increase the student's sense of insecurity and distress and consequently increase the undesired behavior.
- Post the daily schedule in a highly visible place so the students will know what to expect.
- Consider the use of technology. Many students struggling with OCD will benefit from easy access to appropriate technology, which may include applications (e.g., computer-assisted instruction programs, CD-ROM demonstrations, videotape presentations) that can engage student interest and increase motivation.

For additional suggestions on classroom strategies and modifications see "A Teacher's Guide to Children's Mental Health" available from MACMH.

RESOURCES

Anxiety Disorders Association of America
8730 Georgia Ave, Suite 600
Silver Spring, MD 20910
240-485-1001
www.adaa.org
Offers publications, referrals to therapists and self-help groups

Obsessive Compulsive Foundation
676 State Street
New Haven, CT 06511
203-401-2070
Fax: 203-401-2076
www.ocfoundation.org
Free brochures, referrals, newsletter, support groups

Publications:

Anti-OCD Medications and Children: What Every Teacher Should Know. Available from the Obsessive Compulsive Foundation.

Adams, Gail B., Ed.D. & Torchia, Marcia, R.N. *School Personnel: A Critical Link in the Identification, Treatment, and Management of OCD in Children and Adolescents.* Available from the Obsessive Compulsive Foundation.

Kidscope, OCD kids newsletter. Contact: Marilyn London, Editor, Kidscope, P.O. Box 70, Milford, CT 06460-0070

Foa, E. & Wilson, R. *Stop Obsessing.* New York, Reid Bantam Books, 1991.

Oppositional Defiant Disorder

Symptoms or Behaviors

Students with ODD often:

- Lose their temper
- Argue with adults
- Defy or refuse to comply with adults' rules or requests
- Deliberately annoy others
- Blame others for their misbehavior
- Are touchy or easily annoyed by others
- Are resentful and angry

About the Disorder

Students with oppositional defiant disorder (ODD) seem angry much of the time. They're quick to blame others for mistakes and act in negative, hostile, and vindictive ways. All students exhibit these behaviors at times, but in those with ODD, these behaviors occur more frequently than is typical in individuals of comparable age and level of development.

Students with ODD generally have poor peer relationships. They often display behaviors that alienate them from their peers. In addition, these students may have an unusual response to positive reinforcement or feedback. For instance, when given some type of praise they may respond by destroying or sabotaging the project that they were given recognition for.

Some students develop ODD as a result of stress and frustration from divorce, death, loss of family, or family disharmony. ODD may also be a way of dealing with depression or the result of inconsistent rules and behavior standards.

If not recognized and corrected early, oppositional and defiant behavior can become ingrained. Other mental health disorders may, when untreated, lead to ODD. For example, a student with ADHD may exhibit signs of ODD due to the experience of constant failure at home and school.

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Children's Mental Health Fact Sheet for the Classroom

Oppositional Defiant Disorder

Educational Implications

Students with ODD may consistently challenge class rules, refuse to do assignments, and argue or fight with other students. This behavior can cause significant impairment in both social and academic functioning. The constant testing of limits and arguing can create a stressful classroom environment.

Instructional Strategies and Classroom Accommodations

- Avoid power struggles. State your position clearly and concisely.
- Choose your battles wisely.
- Give two choices when decisions are needed. State them briefly and clearly.
- Establish clear classroom rules. Be clear about what is nonnegotiable.
- Post the daily schedule so students know what to expect.
- Praise students when they respond positively.
- Make sure academic work is at the appropriate level. When work is too hard, students become frustrated. When it is too easy, they become bored.
- Avoid "infantile" materials to teach basic skills. Materials should be positive and relevant to students' lives.
- Pace instruction. Reinforce their cooperation by allowing them to do something they prefer or find more enjoyable or less difficult.
- Allow sharp demarcation to occur between academic periods, but hold transition times between periods to a minimum.
- Systematically teach social skills including anger management, conflict resolution strategies, and how to be assertive in an appropriate manner.
- Praise students when they respond positively.
- Provide consistency, structure and clear consequences for the student's behavior.
- Select material that encourages student interaction. However, all cooperative learning activities must be carefully structured.
- Minimize downtime and plan transitions carefully. Students with ODD do best when kept busy.
- Maximize the performance of low-performing students through the use of individualized instruction, cues, prompting, the breaking down of academic tasks, debriefing, coaching, and providing positive incentives.
- Allow students to redo assignments to improve their score or final grade.
- Structure activities so the student with ODD is not always the last one picked.
- Ask parents what works at home.

For additional suggestions on classroom strategies and modifications see "A Teacher's Guide to Children's Mental Health" available from MACMH.

RESOURCES

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Ave, NW
Washington, DC 20016
800-333-7636
Fax: 202-966-2891
www.aacap.org
Information on child and adolescent psychiatry, fact sheets, current research, practice guidelines

Anxiety Disorders Association of America (ADAA)
8730 Georgia Avenue, Suite 600
Silver Spring, MD 20910
240-485-1001
Fax: 240-485-1035
www.adaa.org

Center for Mental Health Services (CMHS)-US Dept. of Health & Human Service, Knowledge Exchange Network (KEN)
PO Box 42490
Washington, DC 20015
800-789-2647
www.mentalhealth.org

Depression & Related Affective Disorders Association (DRADA)
2330 West Joppa Rd.
Suite 100
Lutherville, MD 21093
410-583-2919
www.drada.org

Children’s Mental Health Fact Sheet for the Classroom

PDD and Autism Spectrum Disorders

Symptoms or Behaviors

- Repetitive nonproductive movement like rocking in one position or walking around the room
- Trailing a hand across surfaces such as chairs, walls or fences as the student passes
- Great resistance to interruptions of such movements
- Sensitive or over reactive to touch
- May rarely speak, repeat the same phrases over and over, or repeat what is said to them (echolalia)
- Avoids eye contact
- Self injury

About the Disorder

PDD is an acronym for pervasive developmental disorders, which includes Rett’s syndrome, childhood disintegrative disorder, and Asperger’s syndrome. Another disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), also belongs to this category.

Autistic disorder belongs to the category of disorders known as PDD. According to U.S. Department of Health and Human Services, one in 1,000 to one in 1,500 have autism or a related condition. Autism appears in the first three years of life and is four times more prevalent in boys than girls. Autism is a neurologically based developmental biological disorder whose symptoms can range from mild to severe. The disorder is defined by a certain set of behaviors, but because a child can exhibit any combination of the behaviors in any degree of severity, no two children with autism will act the same.

The terminology can be confusing because over the years autism has been used as an umbrella term for all forms of PDD. This means, for example, that a student with Asperger’s syndrome may be described as having a mild form of autism, or a student with PDD-NOS may be said to have “autistic-like” tendencies. In Minnesota and nationally these are all known as autism spectrum disorders.

Although the American Psychiatric Association classifies all forms of PDD as “mental illness,” these conditions often affect children like a developmental disability. Under Minnesota law, autism and Rett’s are considered developmental disabilities (DD), which means that children with these conditions are eligible for case management and other DD services. Children with Asperger’s, childhood disintegrative disorder, or PDD-NOS may or may not be eligible for these services; although there is provision in state law allowing services for “related conditions.”

A child who is suspected to be autistic should be evaluated by a multidisciplinary team. This team may be comprised of a neurologist, psychiatrist, developmental pediatrician, speech/language therapist, and learning specialist familiar with autism spectrum disorders.

Early intervention is important because the brain is more easily influenced in early childhood. Children with autism respond well to a highly structured, specialized education and behavior modification program tailored to the individual needs of that child. Children with autism range from above average to below average intelligence. Schools need to seek the assistance of trained professionals in developing a curriculum that will meet the specific needs of the child.

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PDD and Autism Spectrum Disorders

Educational Implications

Each child's behavior is unique. Parents and professionals who are familiar with the student are the best source of information. In general, children with Autism usually appear to be in their own world and seem oblivious to classroom materials, people, or events. But a child's attention to you or the material you are presenting may be quite high, despite appearances. Teaching must be direct and personalized in all areas. This includes social skills, communication, and academic subject matter as well as routines like standing in line. Patience, firmness, consistency and refusing to take behaviors personally are the keys to success.

Instructional Strategies and Classroom Accommodations

- Use a team approach to curriculum development and adaptations.
- Materials should be age-appropriate, and relevant to students' lives.
- Maintain a consistent classroom routine. Objects, pictures, or words can be used as appropriate to make sequences clear and help students learn independence.
- Use written checklists, picture charts or object schedules (gym shoes, lunch tray, toy school bus) to show schedule or as checklist for task sequences. If necessary, give instructions one step at a time.
- Minimize visual and auditory distractions. Modify the environment to meet the student's sensory integration needs.
- Help students develop functional learning skills through direct teaching; i.e., teach them to work left to right and top to bottom.
- Teach them to understand social language, feelings, words, facial expressions, and body language.
- Students who get fixated on one subject can be motivated by making "their" topic the content for lessons in reading, science, math, etc.
- If the student avoids eye contact or looking directly at a lesson, allow them to use his/her peripheral vision. Teach students to watch the forehead of a speaker rather than the eyes if necessary.
- Some autistic children do not understand that words are used to communicate with someone who has a "separate" brain.
- Help students learn to apply their learning in different situations.

For additional suggestions on classroom strategies and modifications see "A Teacher's Guide to Children's Mental Health" available from MACMH.

RESOURCES

Autism Research Institute
4182 Adams Avenue
San Diego, CA 92116
619-281-7165
www.autism.com/ari
Provides research-related information, diagnostic checklists

Autism Society of America
7910 Woodmont Avenue
Suite 300
Bethesda, MD 20814-3015
800-3AUTISM
www.autism-society.org
Advocacy, educational information, referral

Autism Society of Minnesota (AuSM)
2380 Wycliff, Suite 102
St. Paul, MN 55114-1146
651-647-1083
www.ausm.org
Provides an introductory class series, information and referral, summer camps

Center for the Study of Autism
P.O. Box 4538, Salem, OR 97302
www.autism.org
Provides an overview of autism and related disorders, articles by Temple Grandin, and links.

Publications:

Powers, Michael D. *Topics in Autism. Educating Children with Autism: A Guide to Selecting an Appropriate Program.* Singular Publishing Group, 1995.

Post-Traumatic Stress Disorder

Symptoms or Behaviors

- Flashbacks, hallucinations, nightmares, recollections, re-enactment, or repetitive play referencing the event
- Emotional distress from reminders of the event
- Physical reactions from reminders of the event, including headache, stomachache, dizziness, or discomfort in another part of the body
- Fear of certain places, things, or situations that remind them of the event
- Denial of the event or inability to recall an important aspect of it
- A sense of a foreshortened future
- Difficulty concentrating and easily startled
- Self-destructive behavior, irritability, and impulsiveness, or anger and hostility
- Depression and overwhelming sadness or hopelessness

About the Disorder

Children who are involved in or witness to a traumatic event that involved intense fear, helplessness, or horror are at risk for developing post-traumatic stress disorder (PTSD). The event is usually a situation where someone's life has been threatened or severe injury has occurred such as serious accidents, abuse, violence, or natural disasters. In some cases, the "event" may be a re-occurring trauma, such as continuing domestic violence.

After the event, children may initially be agitated or confused. Eventually this develops into denial, fear, and even anger. They may withdraw and become unresponsive, detached, and depressed. Often they become emotionally numb, especially if they have been subjected to repeated trauma. They may lose interest in things they used to enjoy.

Students with PTSD often have persistent frightening thoughts and memories of the experience. They may re-experience the trauma through flashbacks or nightmares. These occur particularly on the anniversary of the event, or when a child is reminded of it by an object, place, or situation. During a flashback, the child may actually lose touch with reality and re-enact the event.

PTSD is only diagnosed if the symptoms last more than one month. Symptoms usually begin within three months of the trauma, but occasionally not until years after; they may last from a few months to years. Early intervention is essential, ideally immediately following the trauma. If the trauma is not known, then treatment should begin when symptoms of PTSD are first noticed. Some studies show that when children receive treatment soon after a trauma, symptoms of PTSD are reduced.

A combination of treatment approaches is often used for PTSD. Support from family, school, friends, and peers can be an important part of recovery for children with PTSD. With sensitivity, support, and help from mental health professionals, children can learn to cope with their trauma and go on to lead a healthy and productive life.

Post-Traumatic Stress Disorder

Educational Implications

The severity and persistence of symptoms vary greatly among children affected by PTSD. Their symptoms may come and go for no apparent reason, and their mood may change drastically. Children with PTSD will often regress. They may act younger than their age, which can result in increased emotional and behavioral problems. They may become clingy, whiny, impatient, impulsive, and/or aggressive. They may be unable to perform previously acquired skills, even basic functions like speech. Their capacity for learning may be decreased. They often have difficulty concentrating, are preoccupied, and become easily confused. They may lose interest in activities, become quiet and/or sad, and avoid interaction with other children.

Instructional Strategies and Classroom Accommodations

- Try to establish a feeling of safety and acceptance within the classroom. Greet the child warmly each day, make eye contact, and let the child know that he/she is valued, and that you care.
- Don't hesitate to interrupt activities and avoid circumstances that are upsetting or re-traumatizing for the child.
- Provide a consistent, predictable routine through each day as much as possible. If the schedule does change, try to explain beforehand what will be different and why.
- Consistency shows children that you have control of the situation. However, allow children choices within this pattern wherever possible.
- Try to eliminate stressful situations from your classroom and routines: make sure your room arrangement is simple and easy to move through; create a balance of noisy versus quiet activity areas, and clearly define them; plan your day or class period so that it alternates between active and quiet activities.
- Make yourself available and open to listening, remembering to always respect the child's need for confidentiality.
- Do not tell a child "to forget" about the incident.
- Reassure children that their symptoms and behaviors are a common response to a trauma and they are not "crazy" or bad.
- Incorporate large muscle activities into the day. Short breaks involving simple exercises can help relieve anxiety and restlessness.

For additional suggestions on classroom strategies and modifications see "A Teacher's Guide to Children's Mental Health" available from MACMH.

RESOURCES

Anxiety Disorders Association of America (ADAA)
8730 Georgia Av, Ste 600
Silver Spring, MD 20910
240-485-1001
www.adaa.org

International Society for Traumatic Stress Studies
60 Revere Drive, Ste 500
Northbrook, IL 60062
847-480-9028
www.istss.org

Sidran Traumatic Stress Institute
200 E. Joppa Rd, Ste 207
Towson, MD 21286
410-825-8888
www.sidran.org

National Center for PTSD
VA Medical Center (116D)
215 N Main St
White River Junction, VT 05009
802-296-5132
www.ncptsd.org
Links to interdisciplinary index database, publications, books, research quarterly, clinical quarterly, assessment instruments

PTSD Alliance
www.ptsdalliance.org

Children's Mental Health Fact Sheet for the Classroom

Reactive Attachment Disorder (RAD)

Symptoms or Behaviors

- Destructive to self and others
- Absence of guilt or remorse
- Refusal to answer simple questions
- Denial of accountability — always blaming others
- Poor eye contact
- Extreme defiance and control issues
- Stealing
- Lack of cause and effect thinking
- Mood swings
- False abuse allegations
- Sexual acting out
- Inappropriately demanding or clingy
- Poor peer relationships
- Abnormal eating patterns
- Preoccupied with gore, fire
- Toileting issues
- No impulse control
- Chronic nonsensical lying
- Unusual speech patterns or problems — mumbles
- Bossy — needs to be in control
- Manipulative — superficially charming and engaging

About the Disorder

The essential feature of reactive attachment disorder (RAD) is a markedly disturbed and developmentally inappropriate social relatedness with peers and adults in most contexts. RAD begins before age five and is associated with grossly inadequate or pathological care that disregards the child's basic emotional and physical needs. In some cases, it is associated with repeated changes of a primary caregiver.

The term attachment is used to describe the process of bonding that takes place between infants and caregivers in the first two years of life, and most important, the first nine months of life. When a caregiver fails to respond to a baby's emotional and physical needs, responds inconsistently, or is abusive, the child loses the ability to form meaningful relationships and the ability to trust.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) describes two types of RAD, "inhibited" and "disinhibited." Inhibited RAD is the persistent failure to initiate and respond to most social interactions in a developmentally appropriate way. Disinhibited RAD is the display of indiscriminate sociability or a lack of selectivity in the choice of attachment figures (excessive familiarity with relative strangers by making requests and displaying affection.)

Aggression, either related to a lack of empathy or poor impulse control, is a serious problem with these students. They have difficulty understanding how their behavior affects others. They often feel compelled to lash out and hurt others, including animals, smaller children, peers, and siblings. This aggression is frequently accompanied by a lack of emotion or remorse.

Children with RAD may show a wide range of emotional problems such as depressive and anxiety symptoms or safety seeking behaviors. To feel safe these children may seek any attachments—they may hug virtual strangers, telling them, "I love you." At the same time, they have an inability to be genuinely affectionate with others or develop deep emotional bonds. Students may display "soothing behaviors" such as rocking and head banging, or biting, scratching or cutting themselves. These symptoms will increase during times of stress or threat.

Reactive Attachment Disorder (RAD)

Educational Implications

Many of these students will have developmental delays in several domains. The caregiver-child relationship provides the vehicle for developing physically, emotionally, and cognitively. In this relationship the child learns language, social behaviors, and other important behaviors and skills. The lack of these experiences can result in delays in motor, language, social, and cognitive development.

The student with RAD often feels a need to be in control, which may result in bossy, argumentative, defiant behavior, and frequently results in classroom disruption.

Instructional Strategies and Classroom Accommodations

- Consider a Functional Behavioral Assessment (FBA). Understanding the purpose or function of the student's behaviors will help you respond with effective interventions. For example, a punitive approach or punishment may increase the student's sense of insecurity and distress and consequently increase the undesired behavior.
- Be predictable, consistent, and repetitive. Students with RAD are very sensitive to changes in schedules, transitions, surprises, and chaotic social situations.
- One of the best ways to teach these students social skills is to model the behavior and then narrate for the child what you are doing and why.
- Avoid power struggles. When intervening, present yourself in a light and matter of fact style. This reduces the student's desire to control the situation. When possible use humor. If students can get an emotional response from you, they will feel as though they have hooked you into the struggle for power and they are winning.
- Address comprehension difficulties by breaking assigned reading into manageable segments. Monitor progress by periodically checking if the student is understanding the material.
- Break assignments into manageable steps to help clarify complex, multi-step directions.
- Identify a place for the student to go to regain composure during times of frustration and anxiety.

For additional suggestions on classroom strategies and modifications see "A Teacher's Guide to Children's Mental Health" available from MACMH.

RESOURCES

Connections at Cedar Springs Behavioral Health Systems
www.reactiveattachment.com

Family Attachment Counseling Center
18322-C Minnetonka Blvd
Deephaven, MN 55391
952-475-2818
www.familyattachment.com

Peachtree Attachment Resources, LLC
P.O. Box 49068
Athens, GA 30604
www.attachment-ga.com

The Whole Family Attachment Parenting Association
Calgary, Alberta, Canada
http://members.tripod.com/~JudyArnall/

Publications:

Conducting Functional Behavioral Assessments and Developing Positive Programs for Students with Challenging Behaviors. The Minnesota Department of Children, Families and Learning http://cfl.state.mn.us

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Schizophrenia

About the Disorder

Schizophrenia is a medical illness that causes a person to think and act strangely. It is uncommon in young children — usually striking young people between the ages of 16 and 25. This disorder affects about one percent of the population. Schizophrenia can be difficult to recognize in its early phases.

Schizophrenia usually comes on gradually, and teachers are often the first to notice the early signs. For example, students who once enjoyed friendships with classmates may seem to withdraw into a world of their own. They may say things that don't make sense and talk about strange fears and ideas. Students who show signs of schizophrenia need a prompt mental health assessment.

Early diagnosis and treatment of schizophrenia is important. About 50 percent of people with schizophrenia will attempt suicide; ten to fifteen percent will succeed. Young people with this disease are usually treated with a combination of medication and individual and family therapy. They may also participate in specialized programs.

Symptoms or Behaviors

- Confused thinking (e.g. confusing what happens on television with reality)
- Vivid and bizarre thoughts and ideas
- Hallucinations and delusions, that is, seeing things and hearing voices that are not real
- Severe anxiety and fearfulness
- Extreme moodiness
- Severe problems in making and keeping friends
- Feelings that people are hostile and "out to get them"
- Odd behavior, including behavior resembling that of a younger child
- Disorganized speech
- Lack of motivation

Schizophrenia

Educational Implications

Students with schizophrenia can have educational problems such as difficulty concentrating or paying attention. Their behavior and performance may fluctuate from day to day. These students are likely to exhibit thought problems, physical complaints, may act out, or become withdrawn. Sometimes they may show little or no emotional reaction; at other times, their emotional responses may be inappropriate for the situation.

Instructional Strategies and Classroom Accommodations

- Reduce stress by going slowly when introducing new situations.
- Help students set realistic goals for academic achievement and extra-curricular activities.
- Establish regular meetings with the family for feedback on health and progress.
- Because the disorder is so complex and often debilitating, it will be necessary to meet with the family, mental health, and medical professionals who are treating the student. These individuals can provide the information you will need to understand the student's behaviors, the effects of the psychotropic medication, and how to develop a learning environment.
- Encourage other students to be kind and to extend their friendship.

—from "Schizophrenia: Youth's Greatest Disabler" produced by the British Columbia Schizophrenia Society

For additional suggestions on classroom strategies and modifications see "A Teacher's Guide to Children's Mental Health" available from MACMH.

RESOURCES

Alliance for the Mentally Ill of Minnesota, Inc.
970 Raymond Ave., #105
St. Paul, MN 55114-1146
651-645-2948
http://mn.nami.org

Mental Health Association of Minnesota
2021 E. Hennepin Ave., Ste. 412
Minneapolis, MN 55413
612-331-6840 or 1-800-862-1799
www.mentalhealthmn.org

Web site:

Schizophrenia: Youth's Greatest Disabler produced by the British Columbia Schizophrenia Society www.mentalhealth.com/book/p40-sc02.html

Publications:

Dearth, Labens & Pellegrini, Matt. *Families Helping Families: Living with Schizophrenia, Families of the Mentally Ill Collective.* Avan Books, 1987.

Hoffer, Abram. *How to Live with Schizophrenia.* Citadel Press, 1987.

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Torrey, E. Fuller, M.D. *Surviving Schizophrenia.* Basic Books, 2002.

Walsh, Maryellen. *Schiz-O-Phre-Nia: Straight Talk for Families and Friends.* Warner Books, 1989.

Children's Mental Health Fact Sheet for the Classroom

Tourette's Disorder

Symptoms or Behaviors

- Throat clearing
- Barking
- Snorting
- Hopping
- Vocal outbursts
- Mimicking of other people
- Shoulder shrugging
- Facial grimaces
- Facial twitches
- Blinking
- Arm or leg jerking
- Finger flexing
- Fist clenching
- Lip licking
- Easily frustrated
- Sudden rage attacks

About the Disorder

Tourette's disorder is a neurological disorder that has dramatic consequences for some 200,000 Americans and affects an approximate additional two million to some degree. Boys identified with Tourette's disorder outnumber girls three to one; the disorder affects all races and ethnic groups. Researchers have traced the condition to a single abnormal gene that predisposes the individual to abnormal production or function of dopamine and other neurotransmitters in the brain. Although Tourette's disorder is classified as a mental health disorder, it is usually treated by a neurologist as well as a psychiatrist.

The disorder is still poorly recognized by health professionals. About 80 percent of people with Tourette's disorder diagnose themselves or are diagnosed by family members after learning about the disorder in the media. Many people have symptoms mild enough that they never seek help; many others find their symptoms subside after reaching adulthood.

Symptoms of Tourette's disorder include:

- The presence of multiple motor and vocal tics, although not necessarily simultaneously
- Multiple bouts of tics every day or intermittently for more than a year
- Changes in the frequency, number, and kind of tics and in their severity
- Marked distress or significant impairment in social, occupational, or other areas of functioning, especially under stressful conditions
- Onset before age 18

An estimated 25 percent of students in the US have a tic at some time in their life. Not all students with tics have Tourette's disorder, although they may have a related "tic disorder." Tics may be simple – eye blinking, head jerking, coughing, snorting – or complex – jumping, swinging objects, mimicking other people's gestures or speech, rapid repetitions of a word or phrase. In fact, the range of tics exhibited by people with Tourette's Disorder is so broad that family members, teachers, and friends may find it hard to believe that these actions or vocalizations are not deliberate.

Like someone compelled to cough or sneeze, people with Tourette's disorder may feel an irresistible urge to carry out their tics. Others may not be aware of the fact they are ticing. Some people can suppress their tics for hours at a time, but this leads to stronger outbursts of tics later on. Often, children "save up" their tics during school hours and release them when they return home and feel safe from harassment or teasing.

Somewhere between 50 to 70 percent of students with Tourette's disorder have related learning disabilities, attention deficit hyperactivity disorder (ADHD), obsessive-compulsive disorder, or difficulties with impulse control. Sensory integration problems may explain some behaviors. Depression and anxiety may underlie more visible symptoms.

Minnesota Association for Children's Mental Health • 1.800.528.4511
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Children's Mental Health Fact Sheet for the Classroom

Tourette's Disorder

Educational Implications

Tics, such as eye blinking or shoulder shrugging, can make it hard for students to concentrate. But suppressing tics is exhausting and takes energy away from learning.

Tics may also be disruptive or offensive to teachers and classmates. Peers may ridicule the child with Tourette's disorder or repeatedly "trigger" an outburst of tics to harass. Tension and fatigue generally increase tics.

Please note: *Most students with Tourette's disorder do not qualify for special education services under the EBD classification, unless the coexisting conditions are severe. Some may qualify for services under the category of other health disability (OHD) or specific learning disability (SLD). Others who do not qualify under either the EBD, OHD or SLD categories may do well in a general education classroom with accommodations (504 plans).*

Instructional Strategies and Classroom Accommodations

- Educate other students about Tourette's disorder, encourage the student to provide his own explanations, and encourage peers to ignore tics whenever possible.
- Do not urge the student to "stop that" or "stay quiet".
- Provide adult supervision in high-stress situations such as hallways.
- Refer to the school occupational therapist for an evaluation of sensory difficulties and modify the environment to control light, noise, unexpected touch, etc.
- Help the student to recognize fatigue and the internal and external stimuli that signal the onset of tics.
- Provide a private, quiet place for test taking. Remove time limits when possible.
- Reduce handwriting tasks and note taking. Encourage computer use for composition tasks.
- Give student special responsibilities that they can do well. Encourage them to show their skills in sports, music, art or other areas.
- Provide structured, predictable scheduling to reduce stress and ensure adult supervision in group settings.

For additional suggestions on classroom strategies and modifications see "A Teacher's Guide to Children's Mental Health" available from MACMH.

RESOURCES

Tourettes Syndrome Association of Minnesota
7317 Cahill Road, Suite 233
Edina, MN 55439
952-918-0350
www.tsa-mn.com
Provides family support, Family Learning Camp, newsletter, in-service training for schools

Tourettes Syndrome Association, Inc
National office:
42-40 Bell Blvd., Suite 205
Bayside, NY 11361-2874
718-224-2999
www.tsa-usa.org

Publications:

Haerle, Tracy, ed. *Children with Tourette's Syndrome: A Parent's Guide.* Woodbine House, 1992.

Dornbush, Marilyn P., Ph.D. & Pruitt, Sheryl K. *Teaching the Tiger: a Handbook for Individuals Involved in the Education of Students with ADD, Tourette's Syndrome or Obsessive-Compulsive Disorder.* Hope Press, 1995.

Buehrens, Adam. *Hi, I'm Adam: A Child's Story of TS.* Hope Press.

Video:
Be My Friend. Designed for young children. Available from MN-TSA, see contact information above.